**MN Community Measurement (MNCM)**
**Measurement and Reporting Committee (MARC)**
Wednesday, April 13, 2016
*Meeting Minutes*

**Members Present:** Cara Broich, Ariam De Leon, Peter Dehnel, Howard Epstein, Matt Flory, Tim Hernandez, David Homans, Jordan Kautz, Janet Keysser, Sue Knudson, Robert Lloyd, Caryn McGeary, Tamiko Morgan, Chris Norton, Rahshana Price-Isuk, Jeff Rank, Allan Ross, Laura Saliterman, David Satin, Kris Soegaard, Mark Sonneborn
**Alternate:** Denise McCabe
**MNCM Staff:** Tina Frontera, Amy Krier, Jasmine Larson, Collette Pitzen, Anne Snowden
**Members Absent:** Stefan Gildemeister, Bill Nersesian, Bruce Penner, Jonathan Rose

| Topic | Discussion |
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| **Welcome & Introductions** | Chris Norton called the meeting to order and welcomed committee members and observers. All MARC members and observers introduced themselves.<br><br>Chris reminded everyone that the committee strives to make their meetings and decisions as transparent as possible, but noted that only official MARC members can participate during the meeting discussion. If there are any questions or comments following the meeting, guests can email info@mncm.org. |
| **Approval of Minutes** | The committee reviewed minutes from the March 2016 meeting. **Laura Saliterman made a motion to accept the minutes; Mark Sonneborn seconded the motion. Motion passed.** |
| **Recommendation to convene focused Ad-hoc Depression Measure Development Workgroup – for approval** | Chris introduced the topic of the recommendation to convene a focused ad-hoc depression measure development workgroup. For background, she noted that MNCM's depression measures have been in use since 2008; not only in Minnesota but also in several national programs. Many of the depression measures are NQF endorsed, have been recently re-endorsed, and are reviewed annually by MNCM's Measure Review Committee. With continued opportunity for improvement in depression outcomes as well as the extensive use of the measures in national programs, the proposed measure exploration is focused on three specific topic areas. Chris stated that a complete redesign of the depression measure construct is not in the scope of this recommendation.<br><br>Chris went on to explain that the National Committee for Quality Assurance (NCQA) has proposed a plan to adapt and pilot MNCM's depression measures for HEDIS health plan use, which highlights the need for collaboration and alignment. Chris then introduced MNCM Measure Developer, Collette Pitzen, to present the staff recommendation.<br><br>Collette brought forward a staff recommendation to convene an ad-hoc depression measure development workgroup to potentially enhance MNCM's current depression measures. She noted that this is not related to any contractual obligation.<br><br>Collette reviewed the measure development history and current measure specifications for the Depression Care measures including the attributes of the currently specified PHQ-9 tool. She noted that of the multiple measures in the suite, five are currently endorsed by the National Quality Forum (NQF). Of those five measures:<br>• Three were selected by NQF for re-tooling as e-Measures in the new Measure Authoring Tool<br>• Three were selected for PQRS<br>• Two selected by CMS for Meaningful Use<br>• Two included in the recently published AHIP/CMS Core Measure set<br>• One included in the Accountable Care Organization (ACO) required measures<br><br>Collette explained that as the depression measures have gained more traction nationally, there has been increased interest in broadening their use and applicability. Along with the attention, come questions about the measure specifications (i.e., age range, tools, timeframe, and exclusions) and requests for consideration of measure modification.<br><br>Recently, NCQA launched a plan for measure design that includes the incorporation of clinical data in the construction of measures (ECDS or electronic clinical data submission) and has included an adaptation of MNCM's depression remission and response measures. Collette noted that Medica and PrimeWest are participating in the pilot testing of NCQA's adaptation of these depression measures.<br><br>NCQA's HEDIS measure for the evaluation of health plans is called Depression Remission or Response for Adolescents and Adults (DRR). NCQA notes in their proposal that the measures are adapted from MNCM who is acknowledged as the |

measure steward. Collette indicated that MNCM generally supports NCQA's draft adaptation of the measures for health plan use and recognizes that the draft specifications remain fairly true to MNCM's measure construct. NCQA sought out MNCM's guidance during the development of their measure. There are, however, some key differences, most notably the inclusion of adolescents and the exclusions selected for the measure.

It is a priority of NCQA to use NQF-endorsed measures or to seek endorsement for measures that they develop. While NCQA would be willing to seek endorsement for their adaptation of these measures, NQCA and MNCM staff recognize it would be in the best interest of all stakeholders if MNCM was able to retain stewardship and modify the original depression measures in way that would allow for multiple uses and not create duplication or alignment issues.

Depression is a common, serious and treatable condition whose lifetime prevalence affects 15.7 percent of the population. Many mental health conditions (e.g., anxiety, bipolar, depression, eating disorders, and substance abuse) are evident by age 14 and there is a correlation to recurring depression in adulthood. MNCM's own screening measure for depression or other mental health issues demonstrates 9.7 percent of adolescents in Minnesota screened positively. Clinically, there is strong rationale for depression outcome measures that include adolescents.

The scope of measure development activities would be very focused on specific tasks for exploration. Aligning efforts with NCQA for increased use and applicability is one of the desired goals.

Collette emphasized the importance of taking a holistic approach in an effort to do what is best for patients to improve outcomes and to support alignment and increased use of these high value measures across the nation. The workgroup will report back to MARC at the conclusion of their work which is estimated to be by the end of the year.

**MNCM Staff Recommendation:**
Recruit and convene a measure development work group for a limited and clearly defined scope of work.

**Ad-hoc Review Measure Development Workgroup:**

1. Consideration of changing the age range of the current measure specifications; starting at age 12 (adolescents) instead of age 18 (adults)
    a. Measure could be stratified by age
    b. For adolescents, specifically, review of the allowable two month window for follow-up (e.g., six month remission +/- 30 days is a five to seven month window). A separate NCQA measure exists that allows a 4 – 8 month window of follow up for adolescents for the 6 month measure.
2. Due diligence review of additional or alternative tools to determine fit within current measure constructs.
3. Review of appropriateness of current exclusion criteria (death, nursing home, hospice or palliative care, bipolar and personality disorder) in addition to a review of the additional exclusions proposed by NCQA

**<u>Questions/Comments/Discussion</u>**
David Homan asked for clarification that a single workgroup would be covering all of these topics. Jasmine Larson noted that pediatric and adolescent care providers would be recruited for this workgroup.

Mark asked whether the workgroup was being convened to align with the DRR measure. Collette clarified that the workgroup would review the focus areas to determine if it makes sense to align with the DRR measure. If the workgroup determines that it would not be appropriate to align, there is no obligation to align. Mark asked about consequences if NCQA wants MNCM to continue to be the measure steward, but the workgroup recommendations do not align with the DRR measure. Jasmine noted that if the workgroup recommended not including an additional age strata that includes the adolescent population in the measure, NCQA would most likely seek NQF endorsement of a separate measure set that does include that population. If it is a question of aligning the exclusion criteria, Jasmine pointed out that NCQA's measure specifications are still in draft form so there is still an opportunity for a discussion and NCQA is open to that discussion. If a workgroup is approved to explore considerations and there is not agreement about the exclusions, NCQA may decide that the benefits of aligning with MNCM's established measures outweigh the potential cost of seeking their own endorsement or creating issues of harmonization. NCQA is keenly interested in alignment of these measures, but it's unclear what NCQA will do if alignment does not come to fruition.

Cara Broich explained that Medica chose to participate in the pilot testing of the DRR measure and to have a voice at the table with NCQA. For the pilot, Medica used data from MNCM because Medica does not have the electronic clinical data systems (ECDS) required by NCQA. She noted that CMS is already looking at the DRR measure as a potential Star measure so it's getting national attention. Cara noted that NCQA is listening and Minnesota health plans and MNCM are having influence on this measure. She noted that the hot topic from other health plans on the conference calls for the pilot has been the inclusion of other tools. She additionally commented that health plans seem to be struggling with the pilot of this measure; two plans have dropped out because they can't pilot test the ECDS methodology.

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| | David Homans shared the adage that adolescents are not just small adults and that the workgroup will need to first consider the biological and human aspects of this measure and that issues of alignment would be secondary. He stated that we can't assume that what works for adults will also work for adolescents and need to consider the specificity, sensitivity and reliability of the tools and measures. It's important to have a workgroup composition that also includes primary care and adolescent psychiatry. Additionally, there needs to be consideration for continued exclusion of personality disorders because these patients are extremely difficult to treat and can't be lumped in with depression.<br><br>Laura recommended that the adolescent and adult populations should be considered as different measures. She pointed to the issue of tool validity by age and also noted that some pediatric practices are not only using adolescent tools, but are also using parent-reported tools. She also expressed concern over utilizing the same exclusions for adolescents and adults.<br><br>Sue Knudson presented some feedback she had received from clinic representatives. First, that the workgroup composition include primary care. Second, that tools are evaluated for burden, complexity, and utility. Third, that clinics want to avoid the unintended consequence of motivating providers to over-prescribe for adolescents due to black box warnings on these medications. Lastly, that clinical evidence and what the workgroup thinks is best for the patient should be the first consideration rather than harmonization with NCQA.<br><br>Tim Hernandez expressed concern with the implications for statewide reporting. He additionally noted that the measure development process for the depression measures helped to build infrastructure for treatment that doesn't currently exist in pediatrics. He noted that including adolescents in the depression measure may encourage the development of needed services for pediatric mental health treatment. Allan Ross concurred with Tim's assessment and explained that the lack of treatment infrastructure is even more profound in rural areas which raises concerns of primary care providers prescribing medications for adolescent patients in attempts to treat when other services may not be available.<br><br>David Satin felt it important to note that the workgroup should be empowered to make decisions on exclusions, not because these patients don't deserve treatment, but because the inclusion of certain conditions like some personality disorders affect the ability to effectively measure and compare outcomes for depression. Additionally, the workgroup should also be empowered to bring forth whatever recommendation they find appropriate for the adolescent population (separate, combined, stratified or none). Jasmine noted that the workgroup would have that freedom within the confines of the three key areas of focus.<br><br>Tamiko Morgan commented that many of her concerns had been addressed in the discussion and agreed with others' concerns about the lack of treatment infrastructure for pediatric patients. She noted that this wasn't necessarily a reason not to include adolescents, but something that needs to be taken into consideration. She also expressed concern about labeling patients at such a young age. She noted that the evidenced-based literature on screening adolescents with the PHQ-9 at age 12 is slightly questionable.<br><br>Rahshana Price-Isuk pointed out the possibility that including adolescents in the measure would provide the evidence needed to drive a culture shift to bring more resources to this population.<br><br>Kris Soegaard asked whether NCQA considered handling the adolescent population in a separate measure. Jasmine noted that they had developed an adolescent stand-alone measure separate from the DRR measure.<br><br>David S. asked that the parameters of the workgroup be reviewed. Collette restated the three key focus points of the work group and added one focus point for staff. Work with NCQA staff and their measure development workgroup to consult and advise on measure specification with the goal of MNCM remaining as the measure steward and having specifications that could serve multiple needs.<br><br>Howard inquired whether the workgroup could possibly determine the development of a second measure rather than including adolescents in the existing measure. Jasmine indicated that if the workgroup felt that stratification of results by age wasn't sufficient, they could recommend a separate measure. Rahshana additionally noted the relatively significant differences in follow-up timeframes between the adolescent and adult populations. Howard mentioned that he felt it premature to include the pediatric measure in the existing measure set without much past experience in this area.<br><br>Tim asked whether MARC has the ability to make recommendations on quality improvement versus public reporting. Jasmine noted that the workgroup may make a recommendation but all public reporting activities are ultimately governed by MARC. |

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| | Laura requested that there be adequate and appropriate representation of pediatric providers on the workgroup. Collette assured the group that the policy for workgroup composition will be followed and recruitment efforts will be broad. Jasmine also noted that the co-chairs ultimately approve the workgroup roster. Peter Dehnel recommended specific outreach to pediatric practices as they are not typically part of this process and may not be attentive to general recruitment efforts.<br><br>Jeff noted that in this discussion he had heard there could be a significant downside to adding adolescents to the measure set. He wondered if there was a way to identify unintended consequences. Jasmine explained that unintended consequences are deliberately discussed during the workgroup process as well as during annual measure review.<br><br>Howard reminded everyone that this could impact NCQA's decision making and HEDIS measurement as well as directly affect health plans. He noted that he hoped health plans were also included in workgroup.<br><br>**David Satin made a motion to approve the recommendation to convene a focused Ad-hoc Depression Measure Development Workgroup. The recommendation was amended to incorporate the empowerment of the workgroup to decide what is best for the adolescent patient in terms of outcome measures be it a completely separate measure, a combined measure with adults, a measure that is stratified by age or none at all. Janet Keysser seconded the motion. Motion passed.** |
| **Update on orthopedic surgery outcome measure launch and data submission** | Howard Epstein introduced the next agenda item: an update on the launch of the orthopedic surgery outcome measures as well as MNCM's plan for encouraging some of the orthopedic groups to submit data who have not yet done so. He reviewed previous discussions by MARC about public reporting the orthopedic measures, specifically about how to encourage the two largest orthopedic practices to submit data. At that time, MNCM was exploring options on how best to respond.<br><br>Howard introduced Tina Frontera, MNCM's Chief Operating Officer, to provide the update on what has transpired. Tina began by noting that MNCM began development of the orthopedic outcome measures in 2010 which included Total Knee Replacement, Spine Surgery: Lumbar Fusion, and Spine Surgery: Discectomy/Laminotomy measures. These are the first surgical specialty outcome measures using the Direct Data Submission process. They measure functional status pre-surgery and post-surgery. Postoperative assessment takes time, which causes a lag in the reporting of procedures. In report year 2014, due to low rates of tool administration completed both pre-operatively and post-operatively, only the process measures were publicly reported for 2012 dates of procedure. In report year 2015 (published March 2016), enough data was collected to reliably publish the functional status outcome measures for 2013 dates of procedure.<br><br>A few eligible providers have not reported data for these measures. This includes two large practices which are estimated to account for approximately 40 percent of the cases. After some robust discussion of this topic by this committee last fall, MNCM put forth a plan of action that was approved by the Board. The goal was to have a thoughtful approach that encouraged all orthopedic groups to submit data.<br><br>Integral to this plan was the idea that MNCM's role is to foster transparency rather than enforce compliance. MNCM's planned approach included encouragement of transparency, quality improvement and comparability in a valid and standard way and increased submissions year over year.<br><br>The multi-faceted plan included:<br>• **Send written communication**: Letters were sent to all known orthopedic practices thanking those that submitted, encouraging continuance, and notifying groups that data would be publicly reported and a press release would be issued about the public reporting. Separate letters were sent to the two practices in question asking for individual meetings between MNCM and the groups, and indicating a possible larger multi-stakeholder meeting later.<br>• **Publish results**: Results were publicly released on MNHealthScores.org. These results are ranked in categories (i.e., above average, average, and below average) including a 'Not Reportable' category. 'Not Reportable' indicated that no rate was available due to the group not submitting information, not providing the type of care measured or having too few patients eligible for measurement.<br>• **Issue joint press release with MDH**: The joint press release was sent on Wednesday, March 30. MNCM and MDH staff were interviewed by various media outlets.<br>• **Meet with the groups**: Both of the large orthopedic practices that were identified for individual contact agreed to meet to discuss the measures and reporting. Representatives from MNCM (Jim Chase, Tina Frontera, Anne Snowden, Collette Pitzen) as well as MNCM's Board chair (Tim Hernandez) have already met with one of the groups. Tina indicated that the response from this group was positive. Depending on the response from the second group, it may or may not be necessary to convene a larger multi-stakeholder meeting. The meeting with the second group is scheduled for next week. |

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| | • **Provide tools for new cycle submission**: During the meeting with the first group, they indicated that they will consider 2016 report year (2014 dates of procedure) data submission. MNCM will support this group by providing the tools necessary to complete data submission.<br><br>**Questions/Comments/Discussion**<br>Tim felt staff did well answering questions from the orthopedic group. As with primary care many years ago, data reporting is a culture change for orthopedic practices and will take time. He sensed the meeting was beneficial in allaying fears.<br><br>Chris wondered if there was a sense of when MNCM would know whether this orthopedic group would be participating in data submission for the 2016 report year. Tina felt as if there will be another conversation next week.<br><br>Tim noted that it helped to say that HealthPartners was considering including data submission as part of their contracting. Sue concurred that HealthPartners was considering including this in their contracting and expressed frustration of not being able to see the delineation on the consumer-facing website – MNHealthScores – between groups choosing not to report, those that have submitted but did not meet volume thresholds, and those that are not eligible for the measure. Not having that delineation hamstrings the health plans for including data submission in contracting. She noted that she appreciates the meetings but is disappointed in the timing. Howard noted that other health plans would say the same thing.<br><br>Sue went on to say that the MNHealthScores.org display should be reassessed for usability of the specialty measure results, expressing concern for the amount of scrolling needed to find the medical group she was attempting to identify.<br><br>Matt Flory expressed concern about providers who are choosing not to report being displayed in a general way and how it may appear as a disincentive to groups.<br><br>Howard asked about alternative plans of action if these groups continue to not participate, and inquired about MDH's approach. Tina explained that MNCM may still call a multi-stakeholder meeting, the challenge being whether those groups would attend. The meeting would be an opportunity to express how important this is to multiple stakeholders. Denise McCabe noted that while the legislation does not offer enforcement authority, MDH has a measurement compliance process where groups are notified that their non-compliance has been identified and will be reported. She expressed interest in participating in a multi-stakeholder meeting if one is held and noted that MDH was open to recommendations in terms of compliance enforcement.<br><br>Jeff asked what health plans are doing to encourage participation. Sue reiterated that to move forward they need to know if practices are not reporting or not reportable for other reasons. It was noted that more delineation on MNHealthScores isn't as simple as it seems. It was suggested that short term exploration of options for this issue be held until after the meeting with the other orthopedic practice. In the meantime, MNCM continues to explore communication enhancements.<br><br>Peter asked which works better to encourage participation - monetary incentives or compliance with a mandate. Tim noted that funding was a better motivator for primary care clinics. Anne commented that groups that see the value of using results for internal quality improvement continue to report. With this particular orthopedic practice their concern was about public perception. Once MNCM's measure development, data collection and validation processes were explained, they felt more comfortable with reporting.<br><br>Allan congratulated MNCM on the progress that was made on this issue in the last year. |
| **Update on 2016 MNCM Seminar – Thursday, September 15, 2016** | Howard again turned over the floor to Tina to present information on MNCM's upcoming annual seminar. Tina noted that the all-day seminar is scheduled for Thursday, September 15, 2016. Ann Bancroft will be the keynote speaker and will talk about how she uses measurement to advance her exploration efforts as well as her work with women, children and disadvantaged populations around the world. There will be a panel discussion around adolescent mental health and a break-out about Relative Resource Use as well as use of MNCM's measures. She noted that MNCM is open to sponsorships.<br><br>Tina also mentioned that there will be more information forthcoming on a special strategic MARC session on the topic of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).<br><br>**Questions/Comments/Discussion**<br>Howard requested information about the strategic MARC meeting well in advance. He also inquired about an Early Bird Special for the Seminar. Tina confirmed that there is an Early Bird Registration Special in place until July 15, 2016. |
| **Meeting Adjournment** | Howard announced that the next meeting will be Wednesday, May 11, and adjourned the meeting. |

Next Meeting: Wednesday, May 11, 2016